HEALTH AND HUMAN SERVICES
COUNTY MEDICAL SERVICES PROGRAM
REQUEST FOR REFERRAL SERVICES
TREATMENT AUTHORIZATION REQUEST (TAR)

PATIENT INFORMATION	REFERRING PROVIDER INFORMATION
Patient Name:_____	Name:_____
Address: _____	Address: _____
City/State/Zip: _____	City/State/Zip: _____
Phone Number: _____	Phone Number: _____
SSN: _____ **DOB:** _____	Clinic ID#: _____ Date: _____
Elig:_____ **through** _____ **(month) (year) (month) (year)**	By: _____ (Print Physician's Name)
SPECIALIST INFORMATION	**NOTICE TO PROVIDERS**
Name:_____	Services beyond those authorized in this referral must be specifically authorized by CMS. The referral is valid only when patient is certified. You may verify certificaton when the patient presents his/her identification card . The service must be provided prior to the expiration date noted below. Unauthorized services or services not specifically noted wiill not be honored for payment.
Address: _____	
City/State/Zip: _____	
Phone Number: _____ **Appt. Date:** _____	

SERVICES REQUESTED WITH THIS REFERRAL:_____

_____

_____

CLINICAL INFORMATION, including pertinent lab, x-ray and treatment to date: _____

_____

_____ Clinic MD Signature:_____

Data Enclosed: Lab Reports [ ] X-ray [ ] Narrative Reports [ ] Med. Reports [ ] Other:_____

WRITTEN FINDINGS THAT ARE A RESULT OF THE REFERRAL SHOULD BE PROMPTLY SENT TO THE PRIMARY CARE PROVIDER

TAR NUMBER:_____ BY:_____ EXP. DATE: _____

SERVICES AUTHORIZED: _____

THIS AREA FOR SPECIALIST RESPONSE**:** _____

_____

_____

_____

DATE:_____ Specialist Signature:_____

FOR FURTHER INFORMATION CONTACT: COUNTY MEDICAL SERVICES (CMS) PROGRAM, PO BOX 939016, SD, CA 92193 Phone (858) 495-1300